

AHFSA RAI Panel Questions: January, February and March of 2012

Chapter 2

Question:

Upon an audit of our assessments I have found one of our facilities has not been doing any entry tracking on new residents since the MDS 3.0 was implemented. The facility is completing an entry tracking record when the resident returns to the facility and it is a reentry. The facility thought a new entry was captured by the initial assessment e.g. 5 day PPS or 14 day OBRA. My questions are:

- 1) Does the facility need to complete entry tracking records on current residents in the building?
- 2) Does the facility need to go back to 10/1/10 when the requirement started and complete entry tracking records for ALL residents that were admitted/readmitted to the facility from that time forward?
- 3) Is there anything we can do to avoid sequencing errors in the transmission of these records for CMS?

Answer:

The facility should be completing an Entry Tracking Record on every resident that is admitted or readmitted to the facility, (see RAI Manual Chapter 2, pages 2-32 through 2-34). CMS provided guidance previously that the facility should ensure that residents who were in the facility as of December 1, 2010 have Entry Tracking Records completed and sent to QIES ASAP. However, due to the extended timeframe of this particular issue for the facility, it would be most appropriate that the facility complete and submit Entry Tracking Records for each resident that is currently in the facility and make sure that facility processes are rectified so that Entry Tracking Records are completed and submitted as required. The facility may receive sequence error warnings, but these are expected, and the facility should just be aware that they will receive these in their validation report.

Question:

If a resident dies in the ambulance on the way to an acute hospital what type of discharge assessment should we do? Death in facility or discharge return not anticipated?

Answer:

A Discharge Assessment is not required in this situation. A Discharge Assessment is only required if: 1) The resident is discharged from the facility to a private residence (as opposed to going on an LOA); 2) The resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record); or 3) The resident has a hospital observation stay greater than 24 hours, regardless of whether the hospital admits the patient (see Chapter 2, pg. 2-10).

A Death in Facility tracking record is required if the resident dies in the facility or dies while on leave of absence (LOA).

Since the resident does not meet the conditions under which a Discharge Assessment is warranted, the resident is still considered a resident of the facility and therefore a Death in Facility tracking record is required.

Question:

Please advise based on the scenario below:

- 10/26-Resident admitted
- 11/1-Admission/5D
- 11-7-14D
- 11/15-COT - The date here should have been 11/14
- 11/22-Significant change/30D/COT (this is day 28 of the stay)
- 11/29-COT
- 12/6-COT
- 12/21-60D

A provider realized, after submission to QIES ASAP, that a COT completed on 11/15 should have been completed on 11/14, and that the next COT was also completed incorrectly as a result of the scheduling error. Should the COT completed on 11/15 be inactivated as 'event did not occur' since this was not a valid COT date and an 11/14 COT completed if needed? Likewise, if a COT was also needed on 11/21, should the provider complete one now? Since it is allowable to "open" a COT after the window, there should not be a problem with doing this to fix the scheduling error, correct? If a COT is required for 11/21, then should the 11/22 significant change/30d/COT be inactivated and a new assessment be submitted for 11/22 as a significant change/30d? This was a valid assessment, in the window, but should not have been a COT since the COT was due for evaluation on 11/21. If a COT is not needed on 11/21, then should the 11/22 assessment still be inactivated and a new assessment submitted as a significant change/30d?

Answer:

RAI Manual, Chapter 2 page 71 states that if the COT ARD is not set within the defined ARD window, the facility must treat the assessment as a late assessment. In the scenario described above, the COT was indeed one day late, so must be treated as a late assessment. The facility, in this instance, has to bill the default rate for all days the ARD was not in compliance since the ARD should have been set for the 14th but was set on the 15th. Please refer to the CMS clarification document which was a follow-up to the August 23 provider call and September 1 SNF ODF; page 4 for details. In the scenario described above, the rate from the 11/15 COT would start on 11/8 and would cover until 11/14. A default billing would be in place for 11/15 and the next COT observation period would start on 11/16 and go through 11/22 (which it did). If this observation period showed that a COT was needed, the ARD would be 11/22 and the payment would begin at the new rate on 11/16.

Also, please note, that if the resident is no longer on Part A, the facility cannot set an ARD for any Medicare assessments, so while the facility could inactivate the incorrect assessments, they could not submit corrected assessments.

In the scenario presented, more than 14 days passed, so the facility can no longer set a correct ARD for a COT. Please note: "...no matter when the decision is made as to which day should be set for the ARD on a given PPS assessment, the completion and submission deadlines still apply. Therefore, no matter when a given COT OMRA record is opened and the ARD is entered as the equivalent of Day 7 of the COT observation period, the assessment must still be completed within 14 days of this ARD and submitted within 14 days of the date the assessment is completed," (8/23/11 SNF PPS Clarification document).

By contrast the **March 2012 SNF PPS Clarification Memo** noted below gives the example of setting it back not more than 2 days:

"As stated in the August 23rd clarification memo (which can be found on the CMS SNF PPS website), the ARD for unscheduled PPS assessments can be set for a day within the allowable ARD window after the ARD window has passed. As with the flexibility period allowed for the assessment interviews, the flexibility period for setting the ARD for unscheduled PPS assessments was always intended to be a 1-2 day period, though the previously-issued language may not have been sufficiently specific in establishing the precise end point for the given flexibility as it applied to the ARD for unscheduled PPS assessments. Therefore, we now wish to clarify that the one- to two-day limit is a firm limit on a SNF's ability to exercise this option. In other words, facilities are permitted to set the ARD for an unscheduled PPS assessment for a day within the allowable ARD window, but may only do so no more than two days after the window has passed.

For example: If the third day of missed therapy fell on July 4 and no one was available to set the ARD on this assessment, then the facility could set the ARD for July 4 no later than July 6. To be clear, this should not be considered the same as grace days, which may be used in setting the ARD for a scheduled PPS assessment. In the case of grace days, the ARD for a scheduled PPS assessment may be set for one of the grace days, such as a 5-day assessment with an ARD set for Day 8. By contrast, the two-day flexibility period that applies to unscheduled PPS assessments is different, in that the ARD itself may not be set for one of the two days after the available ARD window. For example, while the decision to set the ARD for a COT OMRA at Day 7 of the COT observation period can occur up to 2 days after Day 7 has passed, the ARD for the COT OMRA may not itself be set for Day 8 or Day 9 without incurring a late assessment penalty.

In certain cases, it is possible that a resident might discharge from the facility unexpectedly during the two day flexibility period. In such cases, the flexibility period still exists and the facility may still set the ARD on the given assessment for a day within the allowable window for that assessment. For example: A COT OMRA is necessary with an ARD of Day 29. The resident then discharges from the facility on Day 30. In this case, the facility may still set the ARD on the COT OMRA for this resident for Day 29, as long as this is done no more than 2 days after Day 29.

We have received some comments and requests to extend this 2 day flexibility period to three days to accommodate weekends and holidays. At this time we do not feel it prudent to extend the flexibility period beyond that which has already been established. In addition, it is important to remember that the MDS is a team-based assessment that requires input from a number of different parties and individuals. The fact that a COT OMRA ARD falls on a Friday or holiday is not sufficient reason for the ARD not to be set on this assessment. Details on the requirements for setting the ARD for a given assessment may be found in clarification 1 in the August 23rd SNF clarification memo, available on the SNF PPS website.”

Question: If a facility missed a COT OMRA that would have resulted in a lower RUG classification and the resident had been discharged from the facility when this was noticed. What is the appropriate action to take? Would the facility bill at the default rate?

Answer:

If Day 7 of the COT observation period is also the day of discharge, then a COT OMRA would not be required. If Day 7 of the COT observation period occurs prior to the date of discharge and the facility fails to set the ARD for the COT before the resident is discharged from the facility and/or from Medicare Part A, then this is considered a missed assessment. Therefore, all days affected by the missed assessment would be provider liable, (i.e. the entire COT observation period and all the days afterward until the resident’s date of discharge). Please refer to the missed assessment policy in Chapters 2 and 6 of the RAI manual for further details.

Question:

Please advise based on the scenario below:

- 11/28/11-Resident admitted
- 12/11/11-5 day (RUC) completed for coverage from 11/28-12/11
- 12/11/11-14 day (RUC) completed for coverage from 12/12-12/27/11
- 12/25/11-30 day completed for coverage starting on 12/28/11.
- 1/2/12-COT completed (which is late by one day as 1/2/12 is day 8)

Per the clarification sent out on 8/23/11, the COT needs to start on the day after the last assessment ARD which in this case is the 30 day, so the COT will be RVA OD 12/26/11-

1/1/12 (7 days) then AAA on 1/2/12 (since the ARD is one day late) as I understand it. My question is this: The next COT is scheduled on 1/9/12 but the RUG did not change from RVA so what RUG do I use for coverage starting 1/3/12?

Answer:

The scenario indicates a misunderstanding of the effect of a late PPS Assessment. A late PPS assessment results in the default RUG (AAA) for all of the days the assessment is late until the date that the late assessment's ARD is set. In the above scenario, this means the facility would bill an AAA from 12/26/11 until 1/1/12. On 1/2/12 (the ARD of the late assessment) the RUG from the MDS (RVA) would become effective and pay until the next assessment required for payment. Please see RAI Manual, Chapter 2, page 2-71: "If the SNF fails to set the ARD within the defined ARD window for a Medicare-required assessment, including the grace days, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the day the omission was identified. If the ARD on the late assessment is set prior to the end of the payment period for the Medicare-required assessment that was missed, the SNF will bill all covered days up to the ARD at the default rate and on and after the ARD at the Health Insurance Prospective Payment System (HIPPS) code established by the late assessment. For example, a Medicare-required 30-day assessment with an ARD of day 41 would be paid the default rate for days 31 through 40 and at the HIPPS code from the assessment beginning on day 41."

Clarification memos have been issued subsequent to the RAI manual. Specifically, in the March 30, 2012 clarification memo, it provides an explicit clarification and direction for treating late unscheduled assessments (the response is accurate with regard to scheduled assessments).

In the case of a late unscheduled assessment, a default payment is assessed for each day that the assessment is out of compliance, including the late ARD. The COT ARD is set for Day 8, which would mean that this assessment is 1 day out of compliance. This would result in one day of default billing. The March 30 clarification memo, specifically page 6, goes on to specify that this default payment is assessed beginning on the day that the assessment would have controlled payment. There are examples to further clarify this point.

Therefore, a default payment should be assessed on the day the COT would have controlled payment, which based on the example would be 12/26/11; then bill the RVA0D from 12/27 forward. If the comparative RUG for the next COT is RVA and the RUG does not change when they do the COT evaluation on 1/9, then they would continue to bill the RVA0D on 1/3 until the next scheduled or unscheduled assessment.

Question:

I have completed an assessment for a resident for a 5 day (A0310B=1), SOT (A0310C=1), ND return anticipated (A0310F=11) and SS (Z0100A=1). The therapy minutes are as

follows: ST (O0400A) 75 minutes and 2 days start date is 01/05/12 (on going); OT (O0400B) 40 minutes and 2 days start date 01/05/12 (on going); PT (O0400C) 50 minutes and 1 day start date 01/06/12 (on going). When I calculate the RUGS I get RMC (Z0100A) and HE1 (Z0150A). The error I get is -3804 "Inconsistent HIPPS code: If A0310C equals 1 or 3, then the first character of Z0100A calculated by the QIES ASAP System must equal R." Can you help determine what the issue is and advise?

Answer:

The SOT is an optional assessment, so if it does not meet the criteria of resulting in a therapy based RUG as noted in your question, the system will not accept the assessment. You indicate that a SOT, if A0310C=1 or 3--, then the MDS must result in a rehab RUG (i.e. begin with an "R") or it will be rejected. It states in the SOT instructions on page 2-47 of the Manual, "Complete only to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a Rehabilitation Plus Extensive Services or a Rehabilitation (therapy) group, the assessment will not be accepted by CMS and cannot be used for Medicare billing." Although staff obtained a rehab RUG of RMC in Z0100C, the RUG used for billing is the index maximized RUG of HE1 in Z0150A – which does not begin with an "R." To rectify the situation, the facility should resubmit the assessment without the SOT as a reason for assessment.

Chapter 2/Section A

Question: A facility that has a recent change of ownership does not yet have their new NPI and State Provider numbers. What do they enter in A0100A (NPI) and A0100C (State Provider Number) on the Assessments/Tracking Records they are completing? Is the NPI the same as the FAC ID?

Answer:

With a change in ownership there are usually two scenarios related to FAC ID and State Provider Number changes (Chapter 2, Section 2.3). The State Provider Number is assigned by the State for Skilled Nursing Facilities/Nursing Facilities (SNF/NF) but not Swing Beds (SB). They are:

1. *A change of ownership (CHOW) with Assignment* indicates that the new owner assumes all assets and liabilities of the previous owner. In this instance, there is a change in owner name which is indicated in ASPEN and no survey is required. There will be no change in the CMS Certification Number (CCN), so A0100B must be completed. There is also no change in the Facility ID (FAC_ID) which is submitted in the header. In regards to A0100C, State Provider Number, this number is the Medicaid Provider Number assigned by the Regional Office and provided to facilities by the State. MDS Coordinators should enter the State Provider Number in A0100C if the facility has one and if the State requires its completion. For Federal purposes, completion of A0100C is not required, and may be left blank if no State Provider Number exists.. The NPI and

FAC_ID are 2 different items/#s. A0100A National Provider Number (NPI) is not a required item, may be left blank. Since the new owner assumes all assets and liabilities of the previous owner and no new FAC_ID issued, there will be no changes in the MDS assessments. The facility would resume the current MDS schedule for all residents.

2. A *CHOW without Assignment* indicates the new owner has terminated the old provider agreement. A new certification survey will be required, as the new owner must be certified. A new provider agreement must also be instituted. Both a new CCN and FAC_ID will be issued. Since the new owner has essentially created a “new” facility, all current residents must have a Discharge Assessment and Admission Assessment completed using the new CCN and FAC_ID and State Provider Number (as issued by Medicaid if applicable). If the provider does not have its state # (A0100C) or FAC_ID, it should contact the State agency to obtain. This information can be found in Chapter 2 of the RAI Manual, pgs. 2-3 through 2-5.

Section A

Question: When submitting assessments, our facility is receiving rejection messages. As far as we know, we are coding the A0310 items correctly. Why do we keep getting rejection messages?

Answer: The facility should ensure that they are using the correct data specifications for submission. The most current version of the data specifications are 1.02.1 (10/1/11). Please consult your vendor to ensure that the appropriate specifications are being used.

Section B

Question:

How do you answer B1000 if the resident had adequate vision without corrective lenses or other visual appliances? Is this even answered, or is it left blank? If you enter “adequate,” how do you answer B1200?

Answer:

Coding Instructions for item B1000 on page B-10 state:

- Code 0, adequate: if the resident sees fine detail, including regular print in newspapers/books.
- Code 1, impaired: if the resident sees large print, but not regular print in newspapers/books.

The addition of the words “with glasses or other visual appliances” means that if residents use them, the facility is to assess the adequacy of vision with these assistive devices in place. The code would be “0 – Adequate,” if the resident sees fine detail with or without visual appliances.

Coding Instructions for item B1200 on page B-12 state:

- Code 0, no: if the resident did not use eyeglasses or other vision aid during the B1000, Vision assessment.
- Code 1, yes: if corrective lenses or other visual aids were used when visual ability was assessed in completing B1000, Vision.

B1200 would be coded as “0 - No,” to indicate that no corrective lenses (contacts, glasses, or magnifying glass) were used to complete B1000.

Section H

Question:

If a resident has stress incontinence and Kegel exercises are part of the intervention, would this be considered a toileting/bladder retraining program assuming that all the other requirements are met?

Answer:

Although there is no mention that Kegel exercises are acceptable in the MDS 3.0 manual, CMS consensus is that Kegel’s are accepted practice especially for stress incontinence and can be a part of a toileting/bladder retraining program. It is best to consult with a urologist regarding which exercises, if any, would be beneficial for the resident.

Section I

Question:

Would it be appropriate to code a diagnosis of delirium as a psychotic disorder in item I5950?

Answer:

No, this would not be appropriate; however, as noted in Chapter 3, Section I, Coding Instructions for Active Diagnoses on page I-4, “If a disease or condition is **not** specifically listed, enter the diagnosis and ICD code in item I8000, Other.” Delirium is defined as a “mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations,” (RAI Manual Chapter 3, Section C, page C-27). Individuals with schizophrenia can exhibit delirium-like symptoms, but this does not mean that they have delirium. Individuals with schizophrenia can have delirium-like symptoms of odd behavior, increased motor activity, odd speech, etc. These symptoms persist without disorientation. Schizophrenics are alert, and their mood is usually consistent (whether it’s depressed or

manic), and although they may be exhibiting psychotic delirium-like symptoms, they can be formally tested. In delirium, the symptoms include marked disorientation between moments of lucidity. Individuals with delirium have inconsistent mood symptoms and are not usually able to be formally tested. A specific defining characteristic of delirium is rapid onset with waxing and waning of confusion and attention.

Question:

Is it appropriate to code Parkinsonism at I5300, Parkinson's Disease?

Answer:

No, they are not the same. Parkinsonism is the general condition that causes a combination of the movement abnormalities seen in Parkinson's disease — such as tremor at rest, slow movement, impaired speech, balance problems or muscle stiffness. These conditions result from the loss of dopamine-containing nerve cells (neurons) but can be caused by a blocking of the action of dopamine. Although Parkinson's disease is the most common cause of Parkinsonism, not everyone who has Parkinsonism has Parkinson's disease. Causes of Parkinsonism can include: Stroke, Medication side-effects (e.g., especially medications used to treat psychosis, major psychiatric disorders and nausea), repeated head trauma such as injuries sustained in boxing, certain neurodegenerative disorders (e.g., multiple system atrophy, progressive supranuclear palsy), and Lewy body dementia.

Section J

Question:

In MDS 2.0, in order for a non-pharmacological pain intervention to be captured for the purpose of MDS, it had to be specifically per physicians order with a measurable objective, goal, etc. Yet, we have many residents for whom we employ non-pharmacological pain relief techniques such as guided imagery, repositioning, gentle but brief range of motion, etc. with documentable results even though we have no specific doctor's order to indicate the duration, required results, etc. Since many of these non-pharmacological interventions are employed by nursing judgment alone without a physician's order, is it appropriate to capture these modalities as non-pharmacological pain interventions on the MDS 3.0? If not, is there a precedent for obtaining a physician's orders for nursing employment of these interventions? Must the doctors order contain anything specific regarding technique, duration, etc.? Also, can we capture interventions based on physician orders related to a specific diagnosis but primarily for comfort? For example, elevation of bilateral lower extremities for residents due to "CHF," or "edema." The same could be said for very frequent repositioning and making sure residents with issues such as hiatal hernias, etc., are OOB for all meals to avoid digestive discomfort. I would greatly appreciate any guidance you can offer.

Answer:

According to the MDS 3.0 manual, item J0100C must have documentation in the medical record that the non-medication intervention is scheduled as part of the care plan, has been received and assessed for efficacy. So any modalities employed need to be part of the care plan and their effectiveness evaluated. The manual does not discuss having physicians orders for nursing modalities. (I think you would only need a physician's order for interventions that require orders, such as PT). The manual addresses many pain relieving interventions, not just ones that require a physician's order. Non-medication interventions need to have been assessed and be on the care plan. They also need to be monitored. There should be very specific documentation as to what interventions were received and their effectiveness. It is important to not misinterpret comfort measures for what would be active pain reducing techniques. In the RAI Manual for non medication pain interventions it states that scheduled and implemented non-pharmacological interventions include but are not limited to bio-feedback, application of heat/cold massage, pt nerve block, stretching and strengthening exercises, chiropractic, electrical simulation, radiotherapy ultrasound and acupuncture. This seems much more specific and would require assessment, care planning, monitoring, documenting, etc.

Section M

Question:

Do topical dressings in M1200E have the same meaning as non-surgical dressings in M1200G?

Answer:

M1200E refers only to topical dressings used in pressure ulcer care. M1200G refers to the application of non-surgical dressings for anything other than pressure ulcer care.

Question:

I have received several questions recently about the coding of "scabs" and where they should be coded on the MDS. Clearly, if the scab is a result of an abrasion, skin tear etc. it is not coded on the MDS. However, if the scab is covering an area that has been assessed to be caused by pressure then it does need to be coded as a pressure ulcer and staged. The problem is that there is nothing in the RAI manual that provides direction for coding this scab. With MDS 2.0, scabs were to be coded as stage 2's when determined to be pressure caused or pressure related. Right now the only place that they could be coded is an unstageable related to eschar and that is not accurate either.

Answer:

It is extremely important to distinguish a scab from eschar. They are different both physically and chemically. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating

surfaces (like pressure ulcers, lacerations, evulsions, etc.) A scab is evidence of wound healing. . Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish it from a scab. A pressure ulcer that was staged as a 2 and subsequently is covered by a scab indicates that it is healing. This should continue to be staged as a stage 2 until fully healed.

Question:

Would it be appropriate to code an enterocutaneous fistula in item M1040D?

Answer:

No because the MDS 3.0 manual defines Open Lesion in M1040D as skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer. Enterocutaneous fistula is one in which there is communication between the intestinal tract and the skin, and therefore does not conform to the definition of an open lesion for purposes of coding the MDS. Some fistulas are created surgically, with gastrostomy, esophagostomy, or colostomy. Others may result from surgical trauma, breakdown of an intestinal anastomosis, or erosions around a surgical drain or tube. Fistulas frequently occur at a suture line, may be complete or incomplete, and are most likely to develop in malnourished patients and in those with impaired blood supply to the intestine, an obstruction distal to an anastomosis, carcinoma of the intestine, or an infected wound.

Question:

Are radiation treatments that have resulted in open ulcerations on a patient coded under burns? The physician referred to these ulcerations as “radiation burns.”

Answer:

Facility staff may only code 2nd or 3rd degree burns caused by heat or chemicals in M1040F. Radiation is neither heat nor a chemical, it is an energy wave, and therefore skin alterations related to radiation treatment are not coded in M1040F.

Section N:

Question:

Are insulin orders received on the day of admission and are part of the admission orders, coded in section N0350B? The question was raised when second bullet from the bottom on page N-3 was read, “If the sliding scale order is new, discontinued, or is the first sliding scale order for the resident, these days CAN be counted and coded.”

The question I have refers to the fact that this item clearly states *since admission/reentry*. The word *since* is defined as between then & now, so to me this would not include admission/readmission orders. It also states to determine if the

physician changed the orders. So I interpret this to mean *changed the orders* after the admission/readmission orders were received. However, it does not clearly state (as it does for O0700) the following - “Does not include standard admission orders, return admission orders,” so is the intent for admission/readmission orders to be included or not included for N0350B?

Answer:

The answer to this question is in the manual on page N-3: If the person received insulin in the look-back period or the orders were changed, it can be coded.

Steps for Assessment

1. Review the resident’s medication administration records for the 7-day look-back period (or since admission/reentry if less than 7 days).
2. Determine if the resident received insulin injections during the look-back period.
3. Determine if the physician (or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws and Medicare) changed the resident’s insulin orders during the look-back period.
4. Count the number of days insulin injections were received and/or changed.

Coding Instructions for N0350A

- Enter in Item N0350A, the number of days during the look-back period that insulin injections were received.

Coding Instructions for N0350B

- Enter in Item N0350B, the number of days during the look-back period that the physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws and Medicare) changed the resident’s insulin orders.

The purpose of this RUG item is to help capture resident acuity. Many times residents are on frequent small doses of insulin in an acute setting, but switched over to a SSI in the SNF/NF. So IF the admission/readmission order is a change from the hospital order then it should be counted as an order change.

Section O:

Question:

A resident had an OT evaluation. No treatment was indicated or provided. Since no treatment was provided would O0400C5 be left blank? If we do put the date of the evaluation in this item then what date is put in item O0400C6?

Since the resident was never treated by therapy there are not any applicable start or end dates of the most recent therapy regimen. Is this correct?

Also, it is my understanding that the dates entered in items O0400C5 and O0400C6 continue to be coded on the MDS even if those dates are 1-2 or more years old as long as the resident has not had any further therapy and no discharges. Is this correct?

Answer:

The look-back for this item is the last 7 days, so if the resident has not had any therapy in that time period (the evaluation doesn't count) then there will be nothing recorded in either O0400C5 or O0400C6. That will be the same answer anytime there is no therapy provided in any discipline. On page O-25 under Therapy Modalities the manual states that only skilled therapy time and the requirements for skilled therapy, shall be recorded on the MDS.

Question:

The RAI manual indicates that for the therapy start date, staff should record the date the most recent therapy regimen (since the most recent entry) started. This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not. Would staff need to complete the therapy items for a resident who has had a therapy evaluation only? If so, do they put in the same date for both the therapy start and end dates?

Answer:

The full definition of Therapy Start Date in the RAI Manual, Section O, page O-16 states: "Record the date the most recent therapy regimen (since the most recent entry) started. This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not, or the date of resumption (O0450B) on the resident's EOT OMRA, in cases where the resident discontinued and then resumed therapy." When the MDS is completed, if there was a therapy evaluation completed and therapy given at the same time, the facility would code the minutes for therapy as administered, in O0400A1-3, O0400B1-3, or O0400C1-3 (as appropriate), and under the Therapy Start Date the facility would put in the date of the therapy evaluation in O0400A5, O0400B5 or O0400C5 (as appropriate). The Therapy End Date in O0400A6, O0400B6 or O0400C6, would have dashes entered since it is being assumed for purposes of this question that therapy will be ongoing. For a resident who only received an evaluation, but never had any therapy, the Therapies section would not be completed. The evaluation/start date and therapy end date is only used for when therapies are actually started and ended.

Section Q.

Question:

Does a person who is designated as a Power of Attorney (POA) qualify as an authorized representative or does that only apply to legal guardians? If a POA is qualified as an authorized representative, does the level of POA matter, for example, durable versus simple healthcare POA?

Answer:

With a durable power of attorney (DPOA), individuals are able to appoint an agent to manage their financial affairs, make health care decisions, or conduct other business when the individual is incapable of making such decisions (i.e. is incapacitated). The power granted to the agent is either general or limited. A general DPOA may allow an individual's agent to do every act which may legally be done by the individual him/herself. A limited DPOA covers specific events, such as selling property, making investments, or making health care decisions. Therefore, a general DPOA can make healthcare decisions among other things, and a limited DPOA specified for healthcare can ONLY make healthcare decisions when the individual is incapacitated. No matter what type of DPOA a resident has, the facility should understand the scope of what is required under healthcare provisions as applicable. If the facility does not understand the resident's DPOA, they should inquire further either with the resident, resident's family, the attorney who executed the DPOA or state officials.

SWING BED QUESTIONS:

Question:

Our swing bed facility Received a patient with multiple (26 to be exact) stage 2 pressure ulcers. Since jRaven only allows a single digit response, how will we be able to capture all 26 pressure ulcers?

Answer:

In the Chapter 3 Introduction on pages 3-4 and 3-5 of the RAI Manual, it states: "When completing the MDS 3.0, there are some items that require a count or measurement, however, there are instances where the actual results of the count or measurement are greater than the number of available boxes. For example, number of pressure ulcers, or weight. When the result of a count or measurement is greater than the number of available boxes, facilities are instructed to maximize the count/measurement by placing a "9" in each box (e.g. k0200B if the weight was 1010 lbs you would enter 999 in the available boxes). Even though the number is not exact, the facility should document the correct number in the resident's medical record and ensure that an appropriate plan of care is completed that addresses the additional counts/measurements."